hospitals and health systems across the country to talk about their infrastructure needs among other issues, and of all the infrastructure needs that they thought of for healthcare broadband for rural areas really rose to the top.

So, we do have a lot of data that we'd be happy to share with you and we'll certainly put into the docket on how hospitals are using broadband including a very recent set of case examples. But, again, I know that the states and local governments have a role to play in sort of prioritizing broadband needs but cannot underestimate the role of the FCC in really being that resource because as you know government budgets at all levels are really quite strapped.

So, thank you for the opportunity to contribute to the conversation.

MS. ONYEIJE: Absolutely. Thank you so much, Chantal. I think as the conversation proceeds one thing we might ask you to address as this goes by is really how hospitals are using telehealth beyond the four walls of the facility.

You talked about lack of adequate broadband being a potential issue, and what we're trying to hone in on is broadband to whom and where. We heard Dr. Galpin talking earlier about making sure that veterans have broadband access at home so that they can get the kind of care that they need after serving our country. So, getting a sense from hospitals about the future of using broadband to care for patients in their homes, understanding how they're going to scale around remote monitoring, that kind of thing would be very useful. So, if I could ask you to think about that and then pipe back in later we'd appreciate that.

MS. WORZALA: Happy to do so.

MS. ONYEIJE: Carolyn, could you announce the next participant?

OPERATOR: We have Emily Moore, Association of State Health Officials. Please go ahead.

MS. MOORE: Thank you. Hi, everyone. My name is Emily Moore and I'm a senior analyst at

MS. ONYEIJE: Absolutely. Thank you so much, Emily. Suleima, can I ask you to just press * and 1? And while you're doing that I know that there are various folks on the line from state and local government and health departments and we really would encourage you to give us any thoughts you have on this issue about reaching the areas that have the greatest critical needs. Also, I think we have on the line folks from Indian country and we would very much value those perspectives as well.

Suleima? I don't know, Emily, if your colleague is on the line.

MS. SALGADO: This is Suleima. Can you hear me?

MS. ONYEIJE: Perfect.

OPERATOR: Suleima Salgado from Georgia Department of Health.

MS. ONYEIJE: Hi, Suleima. Please go ahead.

MS. SALGADO: Thank you. And thank you, Emily, for allowing me to speak as well. Again,

I'm Suleima Salgado with the Georgia Department of Public Health. I run the Telehealth and Telemedicine Program for public health in the state of Georgia.

Just a little bit of background. We currently run a hub and spoke model from our state office down to our county health department. Our state is very decentralized when it comes to public health but we do have a great relationship with all of our 159 counties. All the 159 counties have access to telehealth through our state telehealth program. We currently have more than 400 endpoints throughout the state of Georgia which are endpoints of anywhere we have telehealth equipment, so we provide a variety of services whether it just be used for telehealth videoconferencing, staff training, professional development. We use it more on the administrative side but we also use it to implement telemedicine programs such as behavioral health, a lot of pediatric services through our Children's Medical Service Program, also through our Women, Infant,

and Children Program. So, anything from pediatric complications for asthma, pulmonology, nephrology, pediatric neurosurgery, consultations, sickle cell, we have genetics clinics, infectious disease clinics that we do through our HIV Ryan White Program throughout the state. So, we have probably over different telemedicine programs that we run through our local county health department using broadband and telehealth.

As someone mentioned earlier, the access to broadband has been really significant for us and we're really appreciative of the funds that we are getting through the Rural Health Connect Fund. A majority of our program is funded with the rebates that we get through USAC. Our program probably cost us anywhere from $2.3 to $2.5 million to run per year, and for state government that is a huge undertaking. Normally people don't have those kinds of budgets for telehealth especially in state governments. But with using broadband and having the benefits of FCC funding and the Rural Healthcare Connect Fund in the past

we've been able to get the rebate up to 90 percent on these circuits allowing us to justify in our legislative board to have it approve and understand the value of telehealth.

In the past couple of months it's been very difficult for us kind of just managing and budgeting and looking at where our needs are and our gaps to continue and sustain such a massive program if those funds were to be cut or limited. I know there's a lot of conversation right now given the fact that we've reached that $400 million cap so I just want to kind of consider that as an option.

Most of the districts and counties that we serve, a lot of people don't think of Georgia as having as many rural pockets. But I would be very comfortable to say that at least 50 to 60 percent of our state is rural outside of the metro Atlanta area and we really struggle with even just getting broadband up and running in some of these communities. The cost associated with throwing dedicated T-1 lines of any sort in these

communities is very high cost for these county health departments so we are already working with very limited funding. We do use the old-fashioned hub and spoke model, we do run dedicated lines which a lot of other states and counties use, the existing broadband at AT&T and the wireless clouds, but in these rural counties they don't even have access to that.

So, again, really just realizing that while we are looking at innovative solutions for using broadband in some states and some counties you do have to use the old fashioned antiquated model of kind of how can you even just get broadband into some of these communities. That is a huge gap that we are continuously struggling with any time we kind of just got out there and put telehealth.

And we know that there is a need because there are physician shortages. We look at our Obstetrics Department and we know that 39 of our 159 counties don't even have an OB/GYN in the state of Georgia. So, we use telehealth and

telemedicine to add value to those communities and bring those providers there. But when we get to a place where we're actually ready to build a sustainability plan we realize that the cost of the broadband to get it and to keep it up and running for a year contractor, you know, four years at a time is just way too high for a local municipality to undertake.

So, really I guess my request would be to just kind of really look at the cost of assessing this broadband and really knowing that there are still major areas that don't have access to broadband as a whole.

MS. ONYEIJE: Are there solutions that you would recommend, Suleima? You had put various things on the table here. You've certainly talked about the power of the technology and how you're leveraging that, but you've also talked about gaps and challenges and I'm curious about any solutions or recommendations that you might have for the FCC and other policymakers on the call.

MS. SALGADO: That's a great question.

I really think it would be prioritizing the need. So, when we look at the funds and when funds are released is really looking at the priority of how this money is being utilized. So, if the goal is access to rural areas of the state or rural areas who don't have specialty providers and bridging the gap when you look at diabetes. If there are certain initiatives that are kind of priority I think that should be considered when allocating funds. And I agree with everybody else, we've gotten really innovative as to how you can use it but, again, you're using it for rural and metro area who probably already have access to some provider.

So I really think prioritization should be kind of key and put in the forefront when looking at how these funds should be spent and really looking at the gap. So, if people can give you a case and say, well, justify why you feel you need broadband and why you should receive the rebate or whatever first, I think that would also kind of help weed out those extra organizations

who may not be using it to its maximum capacity.

MS. ONYEIJE: Now, that's very interesting. I'm struck by your comment about the 39 counties that do not have an obstetrician, if I heard you correctly.

MS. SALGADO: Yes, that is correct.

MS. ONYEIJE: I am curious, you talk about the prioritizing about needs. Is the Health Department in Georgia doing that, and if so how? How are you -- everyone has some need,and I'm curious if you have found a way to sort of slice and dice this within your state to figure out, okay, who has the most critical needs for telehealth services and here's how we're going to parcel out our time and resources.

MS. SALGADO: Yeah, we really in public health have looked at not only social determinants of health but population health as a whole so we look at heatmaps throughout our state. We look at telehealth and telemedicine as a way to add value or to bring services to counties where there aren't any available. So we really rely on our

heatmaps and our Medicaid data and our provider data that we get from Medicaid to really notice where those target populations are.

So, if a county comes to us and says, hey, we'd like to use telehealth, can public health help us? Or can our local Georgia partnership with telehealth help us? We really look at those heatmaps and say, okay, what are you considering doing? I'll use cancer as a perfect example. We launched a tele-dermatology program in South Georgia because we looked at the heatmaps and the data that came from Medicaid and Medicare and said most of the cancer is coming from southeast Georgia. Well, what's going on in southeast Georgia? Well, there are a lot of outdoor farm workers, day laborers, linesmen, that work in that cluster of the state. Okay. Do they have providers, yes or no? The number of providers available? And then we cross that with Medicaid data and look at those numbers and then determine where those populations were in those pockets. Then we said, okay, providers in the

community, is there a cancer provider in this area? No. Okay, so here's where we need to be.

So, really looking at your public health data and using the existing resources to determine what the needs are is pretty much how we determine our expansion model and our services.

MS. ONYEIJE: That's very helpful. Do you happen to know whether there is a regional plan that's similar to what you're describing?

MS. SALGADO: So, we work with the Southeast Telehealth Resource Center that's actually based out of Georgia, but I believe they cover Florida, Georgia, Alabama, and South Carolina. So, we have been partnering with them to look at the data to see kind of where we're going. But since we are specifically focused through public health in Georgia that's kind of been our target. But we do look out to them and ask them for resources.

MS. ONYEIJE: Thank you so much, Suleima. We really appreciate it.

I think I want to put one additional

issue on the table at this point and solicit thoughts generally from the group. I think Suleima talks a lot about funding and maybe we should shift to that for a few minutes. Again, just remember you press *1 on your phone to join the conversation at any time.

So, here is the question I would throw out in part based on what I just heard, how are telehealth networks being funded in your communities or nearby communities? Is the funding, like Georgia, primarily federal, is there state funding available, private funding, philanthropy? And if I could ask some normative questions too. Do you believe that we are funding the right things in rural telehealth? Obviously some participants have talked about funding connectivity for healthcare facilities and others have talked about needing connectivity to patient and consumer homes. Are we funding the right thing? What are we doing now and is it the right thing?

And then another strand I think we'd

like to ask you to address is we've heard from rural and underserved communities that sometimes it's not easy to access the various streams of funding available. The Task Force has had numerous stakeholders especially from rural and underserved areas tell us about challenges that they face in navigating what they have called a patchwork of federal and state funding.

So, your thoughts on whether there are ways for federal and state government to better coordinate around telehealth funding, just to make it easier for communities many of whom Suleima was referencing to better access the needed support. If we have thoughts on any of those questions please press * and 1 on your phone.

I will tell you that I'm watching the time here, but I do think the funding question is an important one. So, I don't want us to move forward until we've had a chance to talk about that a little bit. I'm sorry folks, we are having some technical difficulties on this end. Would it make sense... Ben -- can you hear me still?

Suleima just mentioned about working with the Telehealth Resource Center in Georgia which, yes, does cover a number of states. That's just one of 14 telehealth resource centers that our office funds. I think many people on the call are quite aware of telehealth resource centers, but the kinds of things that they're doing in Georgia could absolutely be emulated by a lot of states. And I can say a little bit from my past history of 15 years with the Universal Service Program, not all states are coming close to taking advantage of the resources available as I do know Georgia is.

But way beyond that, and I will comment that our office provides a variety of grants for telehealth and one thing we don't focus very much on is connectivity because from our perspective the Commission is doing a great job with the Universal Service Program so we're not focused on that. But reimbursement and cost are extremely important issues, how to get money to buy equipment and all sorts of other activities. All I will say on that is look at our telehealth

resource centers which cover every state in the country and territories, they are our local experts, our regional experts. They can help point you to sources of funding and have all sorts of training modules.

I recently heard from someone that they didn't know how to find what government resources were available for telehealth which was a little bit surprising given where that question was coming from. Grants.gov every week publishes new funding opportunities and simply searching for telehealth there's a number of things being published. We can't really talk about 2018 because we don't have a budget yet, but when we do there will be plenty of telehealth opportunities. And it is a lot of work for small health care providers to keep track of that, but for instance, states could be notifying all of its constituents that grants.gov has some telehealth opportunities coming up.

MS. ONYEIJE: That's great. Can I ask you to comment on the -- I know you run

competitive grants at HRSA where many of them. Can you talk a little bit to the suggestion that came from Georgia about funding programs, prioritizing the needs based on heatmaps and other things?

MR. ENGLAND: Well, again, commenting a little bit on sort of my past experience, Georgia noted that they're using a lot of T-1 lines and I think that is probably true for a lot of the bricks and mortar facilities. It doesn't obviously touch the broadband 4G, 5G type stuff, the direct to consumers, but that happens to be sort of a sweet spot in the Universal Service Program that makes it more cost effective than maybe some other services.

But, unfortunately, since the Fund that's being referred to has hit its cap the question is some needs are higher than others and there could be a reason to prioritize. Obviously I'm a little biased because I'm in the Office of Rural Health Policy so our focus is very much on rural and our funding authorization safety net

which means we're focused on safety net providers. So, we obviously would think those are the most critical needs that have been identified. Sure, I can certainly see -- if there's not enough money to go around then prioritization based on need seems to make a lot of sense.

MS. ONYEIJE: Fair enough. So, Bill, I'm going to keep you on the line for a minute because I do think it would be useful to move to our second theme here because I fear we're running out of time. In addition to solutions what are the issues that FCC policymakers and other policymakers at the federal, state, local, tribal sort of levels that we need to be keeping top of mind here and staying ahead of? It's critically important for us; in fact, it's part of the charge of the Task Force to help position the Commission to stay ahead of the broadband health curve. One concern we have obviously is sort of potentially unintended effects of leaving folks behind as connected health becomes more common and the gaps between connected communities and isolated

communities become more apparent.

If you have any thoughts on what those emerging issues might be I would ask you to share that. And anyone else who has either solutions or issues to share just, again, press *1 and you can join our conversation.

MR. BARTOLOME: Karen, I think I'd like to specifically ask Eric Frederick with Connected Nation, if he's on the phone, if he has any thoughts on the theme that you just mentioned. I think that would be helpful.

MS. ONYEIJE: Eric, could you press *1, and then Carolyn, can you announce Eric?

OPERATOR: Eric is on the line from Connected Nation. Please go ahead.

MS. ONYEIJE: Hi, Eric. How are you?

MR. FREDERICK: Good. How are you? Can you hear me okay?

MS. ONYEIJE: Yes.

MR. BARTOLOME: Yes, we can, thank you.

MR. FREDERICK: All right, great. As you know, I'm the Community Affairs Director for

Connected Nation. We've been mapping and researching and doing community planning around broadband access, adoption, and use for more than a decade now, and we're big participants in the SBI Program that NTIA ran.

I think on this topic being able to better identify unserved and underserved areas for broadband access and adoption is absolutely critical. When we switched from NTIA maintaining the national broadband map to the FCC's Form 477 data there was a lot of publicly available information, or publicly acceptable information that was lost in being able to examine underserved areas.

So, I think improving the scale of mapping availability data so that we can get a little bit more surgical in the areas that we identify as being unserved by broadband, not only for the infrastructure access itself but also for adoption. I think we've come to a point where we've gone as far as we can with the data that we've collected in making general assumptions

about who is underserved both geographically and socioeconomically, and I think we need to get more surgical with it.

Through our Community Planning Program that we operate at Connected Nation we've been doing very detailed surveys in communities across rural parts of the country in Michigan, and Ohio, South Carolina, Iowa, and other places where we've been asking about healthcare use among residents and sometimes those patterns that we find there don't mirror those at the national level. So, I think being able to better diagnose what areas are underserved by broadband access and adoption as well as being more surgical in how we examine the local community issues will ultimately end up getting more folks connected in leveraging broadband connection for telehealth applications.

MR. BARTOLOME: That's great. Eric, I was wondering, you do a lot of work obviously with communities as part of your organization helping to ensure that broadband is available and adopted in the various communities and states. I was

wondering, do you think it's more effective for folks like in your organization trying to educate and inform folks on the ground about the value of broadband and particularly broadband health, or do you see a role at the federal level that can be effective in trying to motivate and persuade folks on the ground about the value of broadband health technologies?

MR. FREDERICK: That's a good question. I think the answer is there is a role for both. But because we've been working with communities for so long I've found that local community action and support is where the most work gets done. Being able to take information from a federal level and translating that to locals it works okay, but when you start making it personal to the community that you're working in or gathering very hyper-local data for that particular community it suddenly makes it more real so that you're not applying national generalities to a rural county in the middle of northern Michigan, for example. If you can gather information from them and bring

local stakeholders to the table like the healthcare providers, public health agencies, residences, businesses and the like to the table it starts to make it a lot more real.

So, I think taking federal guidelines and federal best practices and advice that have been gathered from across the country is good but ultimately where the work gets done is translating that to the local level and making it very personal so that communities can develop solutions that work for them since every community is different.

MR. BARTOLOME: Thanks, Eric. Karen, do you have any questions? Otherwise we should see who is next in queue.

MS. ONYEIJE: Absolutely. Thank you, Eric. We appreciate that. Carolyn, would you announce the next participant please?

OPERATOR: Yes. We do have Maria Givens from National Congress of American Indians. Please go ahead.

MS. ONYEIJE: Hi, Maria, how are you?

MS. GIVENS: Hi, good, thank you. This call has been really informative. I work at the National Congress of American Indians where we advocate for the 567 tribes in the United States. As most of you guys probably know, tribal lands are the most unserved areas in the country for broadband. Coupling with that the federal government's trust responsibility to provide medical services and healthcare to Indian people we really see a really good opportunity here with telehealth solutions.

So, we know that the Indian Health Service has been working on this issue through their Telebehavioral Health Center for Excellence, and that started in 2009 and it's been growing ever since then. We're just hoping that the FCC and this Task Force can work together with the Indian Health Service to bridge this divide because what we're seeing with our communities is that, as time goes by, there are more communities that feel even less connected in all facets of life, especially with health.

In Indian Health Service, as some of you probably know, the biggest problem is recruiting and retaining qualified professionals, and telehealth is a way that we can really solve that problem, solve the problem for IHS and HHS. This is a way that the FCC through coordinated efforts could really help solve that issue.

So, if anyone on the line wants to get in touch with NCAI later about all of this we have a website, ncai.org, and we can definitely help to point you in the right direction for anything tribal telecom or tribal anything. I just wanted to thank you guys for letting me speak here on this call and also just let the Task Force know that Indian country is really interested in this, we really see a whole lot of potential here, and we definitely don't want you guys to forget about Indian country as you move forward on this.

MR. BARTOLOME: Absolutely not, Maria. Actually, while I have you on the phone if I could just ask a quick question. You mentioned one of the issues is retention of professionals in Indian

country, and I don't know if this is a question you can answer or if it's better directed to the Indian health services at another time, but we're hearing certainly that as you know in rural areas the availability and adoption of broadband-enabled health technology and solutions, such as telehealth and telemedicine, are affected by a variety of different issues and factors like the lack of access to broadband networks, certainly capital resources, hospitals closures unfortunately... [and] you mentioned retention of professionals like physicians. Are those the same issues that are also extant in Indian country or are there any unique issues in Indian country that we should be acutely aware of in trying to close the divide there?

MS. GIVENS: I would say that all of those issues that impact rural communities acutely impact Indian country. Then I think the other piece of this puzzle is that there is a federal trust responsibility to provide healthcare to Indian people. So, it's a little bit different

than the health system of the rest of the country, but there is a federal responsibility to make these systems work. It's no secret that there is room for improvement at IHS. We think this is a really cool, interesting way to number one bring broadband to communities but also to help fulfill that trust responsibility.

MR. BARTOLOME: Okay. Thank you very much.

MS. ONYEIJE: Thank you so much, Maria. I'm going to ask if Patty and Kevin and Maureen would mind pressing *1 here. We wanted to get your views on these emerging issues question just from your unique perspectives. Patty, for example, you were talking a little bit about what I would call future proofing issues right at the top of the hour. And I'm curious just from each of you, what emerging issues are you seeing from your perches?

So, Patty, are you on the line?

OPERATOR: One moment while the lines are opened.

DR. MECHAEL: This is Patty again. I think from our perspective at the Personal Connected Health Alliance some of the emerging issues that we're seeing are really around interoperability and the ability to evenly move data from various systems. So, when you're talking about telehealth and now you're introducing remote patient monitoring, and increasingly people want to have their wearable data integrated into their electronic health record and integrated into clinical practice, what we're finding is that making sure that there are clear guidelines and architectures out there that can facilitate safe, secure data exchange between different sources of information.

So, that's a real big area that we're seeing coming up, especially if you start to think about like the internet of things where everybody wants everything everywhere they go and they want all of their data in one place which from a health outcomes perspective is going to be really, really critical as well. So, having as much information

up to date in the hands of individuals themselves as well as their providers is mission-critical.

And then the other one is really around -- and somebody alluded to this before -- reimbursement and what actually gets covered and what gets paid for. We are moving into a virtual world in which health-related interactions increasingly are happening very differently than they had in some of the traditional models. So, making sure that the financing and the ability to make sure that healthcare providers are getting paid for the services that they're providing irrespective of where they're located, but also dealing with issues around jurisdiction. So, can a healthcare provider who is board certified in one jurisdiction provide teleconsultations and health services in another one.

MS. ONYEIJE: That's fascinating. You mentioned IOT, so I am curious about whether the widespread adoption of things like remote patient monitoring -- I think that Dr. Galpin was talking about the 2000-fold increase that he anticipates

in the veterans' space. For things like remote patient monitoring and IOT solutions do you anticipate or do you see ways in which the kind of connectivity that's necessary for all the participants at facilities, patients and caregivers, will change? I think that there are some folks who have been saying that we do need to start thinking about more episodic access to connectivity to address this kind of care delivery, but I'm curious about your views.

DR. MECHAEL: I think universal access is an important issue in the same way that -- universal access to broadband is important alongside universal access to healthcare and health services. I think those two go very much hand in hand. I think we need to do better assessments of the types of broadband connectivity that are going to be needed in a world where more and more interactions are requiring higher bandwidth and really make informed decisions about where to invest resources and how to invest those resources.

So, remote patient monitoring, synchronous teleconsultations, these are increasingly bandwidth-intensive and so if we're moving into a world where we're doing continuous monitoring, which is the recommendation in some healthcare situations, and moving care into the homes I think that's going to require a whole other conversation around bandwidth.

MS. ONYEIJE: Very interesting. So, I'm going to pull Kevin back into the conversation here. Are there emerging issues that you are seeing in the veterans' space or that you're observing more generally across the country?

DR. GALPIN: I think going back to just into the home that's where we are, and I think the universal ability to have broadband connectivity in some form is what we're really looking to as the next goal.

One issue that I don't know if I'm seeing it specifically but I think we all know is an issue is just the idea of clinical capacity. I mean, are there enough providers out there, are we

going to see a lot of providers retiring and not being replaced as quickly? Do we have the work force? I think this is another area where having broadband universally available makes a difference. Through telehealth, we strongly believe we can expand the workforce because as people retire part of the reason they want to retire is they want to move to a new location, maybe closer to family or out of a big city where there's hustle and bustle. We want to be able to connect to where the providers are too. So, there are providers that move out to rural communities, they want to live at a lake house and go fishing, and we want to give them an opportunity to maintain work in the medical sector and broadband in rural areas is a way to capture that piece of the workforce and hopefully expand the entire clinical workforce.

So, I think the concept of do we have enough providers to manage all the care that we're going to need to have and how do we extend our providers, how do we expand that workforce, and

MS. LEWIS: I am.

MS. ONYEIJE: -- but if you have any thoughts on emerging issues, whether on the data side or elsewhere please.

MS. LEWIS: I did just want to mention that our 2015 survey data revealed something interesting about multiple device users versus those who just use a single device to connect to the internet. We are finding that people who have multiple connections either using personal computers, tablets, smartphones, tend to conduct more activities online including engaging in health-related activities. So, for example, single device users with smartphones were less likely to seek health information online than personal computer only users.

So, I know that a number of underserved communities tend to over-index on the use of smartphones. I just want us to sort of be aware that this is just one data point from one year, and our 2017 survey may shed more light on this, but we may want to be sensitive to how people are

accessing the internet based on the devices that they're using. And I know that as we've talked today there is a lot being delivered through smartphone technology but we want to also make sure that, as we are looking to smartphones as a way to deliver more connectivity, that we're perhaps relying on it appropriately and not overemphasizing its utility. It's important but we'll kind of see where the data go in future years, but we're kind of tracking this closely.

MS. ONYEIJE: That is a very good point. It comes back to that question of not only the quality but the kind of connectivity that will really be needed to allow consumers in rural and underserved areas and beyond to sort of participate in the connected care future that Patty and others have been talking about.

I knew this was going to happen. We wanted to make sure that we were respectful of your time. But before we close the session -- because we're right at 3:00 now -- we did want to just open this up to anyone else who wanted to put

any other comment or give any other input just press *1 and we will recognize you. We at the Task Force are certainly willing to stay a little bit over if needed.

If you would prefer to reach out to us separately we are happy to engage with you offline. That is also another core element of the Task Force's sort of objectives and our charge is to have as broad an outreach to stakeholders across the country as possible.

So, we completely understand if folks need to go. We know what we're on various time zones here so we appreciate that. Carolyn, please let me know, I think folks are probably going to reserve their additional comments. I can't quite see any more whether there are folks in the queue or not.

OPERATOR: There are no commenters in the queue at this time.

MS. ONYEIJE: Thank you. So, what I'd like to do then is to thank you for participating today. This was really an outstanding session and

it's given us a lot of food for thought. We greatly appreciate the input that you provided.

There are so many things I could highlight here and there are a few that stand out. I heard over and over broadband as an enabler, the drive to move broadband and health from healthcare facilities to the home, that there really is a compelling case for telehealth and we just need to figure out how to make sure that people are not being left behind, to some of the questions about relevance and the fact that health may be a use case that addresses that relevance question, to the issue of physician shortages and broadband as a force multiplier.

So, I just want to thank everyone again for their thoughtful input. If you have additional comments you want us to consider please reach out to us at connect2health@fcc.gov or submit more formal comments.

There is a wealth of information on the FCC's broadband health hub for those who have not been following our work which is fcc.gov/health.

So, for example, the critical need counties that I was talking about earlier -- those are on there -- the Mapping Broadband Health in America Platform is available there.

And I just want to wish everyone a wonderful afternoon and thank you again for your participation. Carolyn, would you please make final announcements and conclude the session?

OPERATOR: Thank you. Ladies and gentlemen, that does conclude your conference for today. Thank you for our participation and for using AT&T Executive Teleconference Services. You may now disconnect.

(Whereupon, at 3:04 p.m. the PROCEEDINGS were adjourned.)

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I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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Commission No. 351998
Expires: November 30, 2020